DEPARTMENT OF HEALTH AND HUN	MAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES
STATEMENT OF DEFICIENCIES	X1) PROVIDER

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/11/2014		
	VIDER OR SUPPLIER			12011 \	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD		
ADAMS HER	RITAGE			MONK	OEVILLE, IN 46773		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
St th according to the state of	tate Licensure See Indiana State Ecordance with Aurvey Date: 09/20 acility Number: rovider Number: 20 acres of Number: 20 acre	002549 :: 155729	K01	0000	Preparation and execution of the plan of correction does not constitute admission or agreement by provider to the the of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction prepared and executed solely because it is required by the provisions of federal and state law. adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are the of such character as to limit the provider's capacity to render adequate resident care. Furthermore, adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plof Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of September 2014. Further, we request decreview (paper compliance) for compliance, if acceptable. Completion dates are provided procedural processing purpose to comply with federal and state regulations, and correlate with most recent contemplated accomplished corrective action. These do not necessarily	ruth n is s o ne they e g an to 6, sk or es te the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01		
		155729	B. WINC	3 <u> </u>		09/11/	ZU14
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
A D A \$ 40 L	IEDITACE		12011 WHITTERN RD MONROEVILLE, IN 46773				
	HERITAGE				JEVILLE, IIN 40//3		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAU		of 52 at the time of this		TAG	chronologically correspond to the		DATE
		of 32 at the time of this			date that Adams Heritage is		
survey.			under the opinion that it was in				
	All arong where t	the residents have			compliance with the requireme		
					of participation or that corrective action was necessary.	/e	
<u> </u>		s were sprinklered. facility services which			dollon was necessary.		
		ered were a detached					
	•	rage of maintenance					
		and the facility's bus.					
		-					
Another detached shed used for storage of maintenance supplies.							
of manitenance supplies.							
Quality Review by Lex Brashear, Life							
	•	cialist-Medical Surveyor					
	on 09/15/14.	cianst-wedicar Surveyor					
	011 0 // 1 3/ 14.						
	The facility was	found not in compliance					
	•	entioned regulatory					
	requirements as 6						
	following:						
	rene wing.						
K010025	NFPA 101						
SS=D	LIFE SAFETY CO						
		e constructed to provide at our fire resistance rating in					
		.3. Smoke barriers may					
	terminate at an atr	ium wall. Windows are					
		ated glazing or by wired					
	•	steel frames. A minimum impartments are provided					
	•	npers are not required in					
	duct penetrations	of smoke barriers in fully					
	ducted heating, ve						
	conditioning system 19.1.6.3, 19.1.6.4	ms. 19.3.7.3, 19.3.7.5,					
	•	ation and interview, the	K01	0025	K025		09/13/2014
		ensure 1 of 1 ceiling		- 0-0			25, 20, 201 !

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 CO			COMPLETED		
		155729	B. WIN			09/11/2014		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
A D A M C I	IEDITACE		12011 WHITTERN RD					
ADAMS F	HERITAGE			MONROEVILLE, IN 46773				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	smoke barriers w	vas maintained to provide			1. What corrective action will	<u>i</u>		
		esistance rating. LSC			be accomplished for			
		· ·			those residents found to have	<u>'e</u>		
	-	noke barriers shall be			been affected by this			
		an outside wall to an			alleged deficient practice?			
	outside wall. Th	is deficient practice was			Mechanical room is always			
	not in a resident	care area but could affect			locked. Both penetrations			
	facility staff.				were sealed immediately.			
	racinty stair.							
	F: 1: : 1 1				2. How other residents having	<u>ıg</u>		
	Findings include				the potential to be			
					affected by the same deficien	<u>ıt</u>		
	Based on an observation with the Maintenance Supervisor on 09/11/14 at				practice will be			
					identified and what corrective	<u>e</u>		
		were two unsealed three			action(s) will be taken?			
	· ·				None identified. Mechanical			
	•	ing penetrations in the			room is always locked.			
	electrical area of	the main mechanical			And both penetrations were			
	room. Measurer	nents were provided by			sealed immediately			
		Supervisor at the time of			3. What measures will be put	,		
	observation.	supervisor at the time of			into place or what	-		
	ooservation.				systemic changes will be ma	nde		
					to ensure that the	<u>uc</u>		
	3.1-19(b)				deficient practice does not			
					recur?			
					Monthly environmental rounds			
					are performed to			
					make sure all penetration are			
					identified and			
					corrected.			
					4. How the corrective action	<u>(s)</u>		
					will be monitored to			
					ensure the deficient practice	_		
					will not recur?			
					Information gathered from the			
					audits will be			
					forwarded to the QA committee	e		
					for recommendations			
					and review monthly for two			
					months, then quarterly			

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NAME OF PROVIDER OR SUPPLIER ADAMS HERITAGE STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773 (X4) ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG THE REGULATORY OR LSC IDENTIFYING INFORMATION) THE REGULATORY OR LSC IDENTIFYING INFORMATION THE REGULATORY OR LSC IDENTIFY INFORMATION THE REGULATORY OR LSC IDENTIFY INFORMATION THE		IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
ADAMS HERITAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG THE REPROPRIATE DEFICIENCY TAG THE REPROPRIATE DEFICIENCY THE REP			155729	B. WING		09/11/2014		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG TAG (EACH DEFICIENCY) PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Thereafter. QA committee will recommend that we continue the environmental rounds on a monthly basis. 5. By what date the systemic changes will be				12011 WHITTERN RD				
recommend that we continue the environmental rounds on a monthly basis. 5. By what date the systemic changes will be	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
K010029 SS=E LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1		LIFE SAFETY CO One hour fire rated hour fire-rated doc automatic fire extinaccordance with 8 protects hazardou approved automat system option is u separated from ott resisting partitions self-closing and no protective plates the inches from the both permitted. 19.3. Based on observing facility failed to for 1 of 1 Prairie used to store soil creating a hazard close and latched. This deficient prosmoke compartments of the same compartments. Same and the compartments of the same and the compartments of the same and the sam	d construction (with 3/4 brs) or an approved inguishing system in .4.1 and/or 19.3.5.4 is areas. When the ic fire extinguishing sed, the areas are her spaces by smoke and doors. Doors are on-rated or field-applied hat do not exceed 48 bittom of the door are 2.1 action and interview, the ensure the corridor door Path shower rooms, and linen therefore dous area, would self into the door frame. Could affect 1 of 5 ments.	K010029	recommend that we continue the environmental rounds on a monthly basis. 5. By what date the systemichanges will becompleted? September 13, 2014 K029 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? The door closer was replaced repair the latch. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?	09/13/2014 11 12 10 10 10 10 10 11 11 11 11 11 11 11 11		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155729	B. WING		09/11/2014		
	PROVIDER OR SUPPLIED HERITAGE	R STATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773 ID (X5)				
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K010038	corridor door to room, containing soiled linen, did latch into the do observation, the acknowledged th	the Prairie Path Shower g 8 trash bags full of self close but failed to or frame. At the time of Maintenance Supervisor he Prairie Path shower to store soiled linen.		affected by the same deficient practice would be identified as those shower doors that does not latch. No were so identified. 3. What measures will be purinto place or what systemic changes will be most to ensure that the deficient practice does not recur? Monthly environmental rounds performed by Maintainence supervisor and Administrator bi-weekly for two months, then monthly thereafter to ensure the shower doors latch appropriately. 4. How the corrective action will be monitored to ensure the deficient practice will not recur? Information gathered from the audits will be forwarded to the QA committ for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend that we continue the environmental rounds on a monthly basis. 5. By what date the systemic changes will be completed? September 13, 2014	ne t ade s will ee		
1.010000	141174 101						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	BUILDING 01		COMPLETED		
		155729	B. WIN			09/11/2014		
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				WHITTERN RD			
	HERITAGE			MONRO	DEVILLE, IN 46773			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	PLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	D	ATE	
SS=E	LIFE SAFETY CO	DE STANDARD inged so that exits are						
		at all times in accordance						
	with section 7.1.	19.2.1						
		ation and interview, the	K01	0038	K038	09/1	3/2014	
		ensure the means of			1. What corrective action will	_		
		5 exits was readily			be accomplished for			
	_	stant use in the event of			those residents found to have	<u>e</u>		
		n 19-2, Means of Egress			been affected by this alleged deficient practice?			
		equires every exit			anogea achorent practice:			
	•				Signs were covered with black			
	_	ocation and access shall			poster board.			
		with LSC Chapter 7.			l			
		nns of Egress Reliability,			2. How other residents having	<u>19</u>		
	requires the mean	•			the potential to be affected by the same deficien	,,		
		of impediments to full			practice will be	<u>"</u>		
	instant use in cas	se of fire or other			identified and what corrective	<u>e</u>		
	emergency. Add	litionally, LSC Section			action(s) will be taken?	_		
	4.6.10 allows but	ildings or portions of						
	buildings to be o	ccupied during			Other residents that could be			
	construction, rep	air, alterations, or			affected by the same deficient practice would be			
	additions only if	all required means of			identified as those exit			
	egress and all red	quired fire protection			signs not covered during			
	•	ace and continuously			construction. None were			
	_	ne portion occupied.			so identified.			
		actice affects 1 of 5			3. What measures will be put			
	smoke compartm				into place or what	-		
	Smone compartin				systemic changes will be ma	<u>de</u>		
	Findings include				to ensure that the	-		
	r manigs include	•			deficient practice does not			
	Danadan dan	-4ii4l- 4l			recur?			
	Based on observa				Future construction will be clos monitor to ensure	seiy		
		nd the Maintenance			Exit signs are covered by door	s		
	•	0/11/14 at 11:08 a.m.,			were construction			
	exit signs in the	•			Is affecting the entrance.			
		eting all occupants to use						
	the main entranc	e in the event of an			4. How the corrective action	<u>(s)</u>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLI	
		155729	B. WIN	G		09/11/	2014
	PROVIDER OR SUPPLIER HERITAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K010046 SS=E	the Maintenance observation, a neconstruction at the entrance/exit is not construction there should be removed confusion. 3.1-19(b) NFPA 101 LIFE SAFETY CO Emergency lighting duration is provided 19.2.9.1. Based on observation observation of the capable of reproperation. This caffect residents in Heritage Hall. Findings included Based on observation observation.	g of at least 1½ hour and in accordance with 7.9. ation and interview, the ensure 2 of 5 battery ncy lighting fixtures LSC 7.9.2.5 requires emergency lights shall be ated automatic deficient practice could near the main lobby and	K01	0046	will be monitored to ensure the deficient practice will not recur? Information gathered from the audits will be forwarded to the QA committee for recommendations and review monthly for two months, then quarterly thereafter. QA committee will recommend time frame for continuing monitoring 5. By what date the systemic changes will be completed? September 13, 2014 K046 1. What corrective action will be accomplished for those residents found to hav been affected by this alleged deficient practice? Battery replaced in main lobby emergency light and exit door light in Heritage hall. 2. How other residents havin the potential to be affected by the same deficien practice will be identified and what corrective action(s) will be taken? Other residents that could be affected by the same deficient practice would be	g. <u>I</u> <u>re</u> n <u>q</u>	09/13/2014

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			COMPLETED
		155729	A. BUIL B. WIN			09/11/2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R				
	IEDITACE				WHITTERN RD DEVILLE, IN 46773	
ADAMS I	HERITAGE			WONK	DEVILLE, IN 46773	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	he acknowledge	ed the battery operated			identified as those exit	
	emergency light	s in the main lobby and			door lights or emergency lights	S
		or in Heritage hall failed			not working. None were	
	to illuminate wh	_			so identified.	
	to mummate wi	ien tested.			2 14/6-4	4
					3. What measures will be put	<u>L</u>
	3.1-19(b)				into place or what systemic changes will be ma	odo
					to ensure that the	ide.
					deficient practice does not	
					recur?	
					Monthly environmental rounds	s will
					performed by	
					Maintainence supervisor and	
					Administrator to ensure	
					the exit lights and emergency	
					lights are working.	
					4. How the corrective action	(s)
					will be monitored to	1-7
					ensure the deficient practice	<u>.</u>
					will not recur?	
					Information gathered from the	
					audits will be	
					forwarded to the QA committe	ee
					for recommendations	
					and review monthly for two	
					months, then quarterly	
					thereafter. QA committee will recommend that we	
					continue the environmental	
					rounds on a monthly basis.	
					5. By what date the systemic	<u>c</u>
					changes will be	
					completed?	
					September 13, 2014	
1/040000	NEDA 404					
K010062	NFPA 101	DE CTANDADD				
SS=F	LIFE SAFETY CO					
		tic sprinkler systems are ntained in reliable operating				
		named in reliable operating	ı			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01		
		155729	B. WIN	IG		09/11/	2014
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					WHITTERN RD		
ADAMS	HERITAGE			MONR	OEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		inspected and tested					
	NFPA 25, 9.7.5	.7.6, 4.6.12, NFPA 13,					
		review and interview,	K0	10062	K062	,,	09/18/2014
	the facility failed	d to ensure 1 of 1 private			1. What corrective action will be accomplished for	<u>"</u>	
	fire hydrants wa	s continuously			those residents found to have	⁄e l	
	maintained in re	liable operating condition			been affected by this		
	and inspected and tested periodically.				alleged deficient practice?		
	NFPA 25, 1998	Edition, the Standard for			Hydrant was inspected by VF	P	
	the Inspection, T	Testing, and Maintenance			Systems, Fort Wayne, IN		
	of Water-Based	Fire Protection Systems					
	at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and				2. How other residents havi	ng	
					the potential to be		
	after each operation. Hydrants shall be				affected by the same deficie	<u>nt</u>	
	_	e necessary corrective			practice will be		
		aken. This deficient			identified and what corrective	<u>′e</u>	
		ffect all staff, visitors and			action(s) will be taken? Other residents that could be		
	residents.	riect all staff, visitors and			affected by the same		
	residents.				deficient practice would be		
	T: 1: : 1 1				identified as those hydrant		
	Findings include) :			not being inspected yearly. N	one	
					were so identified.		
		review and interview			30 Identified.		
		nance Supervisor on			3. What measures will be pu	<u>t</u>	
		5 a.m., the last annual			into place or what	_	
	inspection for th	e private fire hydrant on			systemic changes will be ma	ade_	
	the facility's proj	perty was 08/27/13.			to ensure that the		
	Based on an inte	erview with the			deficient practice does not recur?		
	Maintenance Su	pervisor at the time of			Monitor dates of previous		
		e is aware of the previous			inspection closely.		
		and has contacted the			Call 2 months in advance.		
		any for an annual					
	inspection.	-			4. How the corrective action	<u>ı(S)</u>	
	-F				will be monitored to ensure the deficient practice	,	
	3.1-19(b)				will not recur?	-	
	17(0)				Information gathered from the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
ANDILAN	OI CORRECTION	155729	A. BUILDING	01	09/11/2014
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	33 23
NAME OF P	ROVIDER OR SUPPLIER			WHITTERN RD	
ADAMS I	HERITAGE			OEVILLE, IN 46773	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
				audits will be forwarded to the QA committed	
				for recommendations	
				and review monthly for two	
				months, then quarterly thereafter. QA committee wil	
				recommend time	
				frame for continuing monitoring	ng.
				5. By what date the system changes will be	<u>ic</u>
				completed?	
				September 18, 2014	
K010147	NFPA 101				
SS=D	LIFE SAFETY CO Electrical wiring ar	-			
	accordance with N	IFPA 70, National			
	Electrical Code. 9.		K010147	K147	09/26/2014
		ation and interview, the ensure 1 of 1 flexible	K01014/	1. What corrective action wi	
	_	sed as a substitute for		be accomplished for	
		rovide power equipment		those residents found to ha	<u>ve</u>
		ent draw. NFPA 70,		<u>been affected by this</u> alleged deficient practice?	
	_	cal Code, 1999 Edition,		Refrigerator was unplugged f	rom
		quires that, unless		the power strip until	
		nitted, flexible cords and		new outlet is installed.	
		be used as a substitute for		2. How other residents have	<u>ing</u>
		structure. This deficient		the potential to be	
	•	in a patient care area but		affected by the same deficie	<u>ent</u>
	could affect main	ntenance staff.		practice will be identified and what correcti	ve
				action(s) will be taken?	
	Findings include	:		Other residents that could be	
				affected by the same deficient practice would be	
		ation and interview with		identified as those refrigerato	r
		or and the Maintenance		plugged into a power strip. N	
	-	0/11/14 at 12:00 p.m., he		were identified and	
	acknowledged a	refrigerator was plugged		maintenance door is always	

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	01	COMPLETED	
		155729		LDING		09/11/2014	
		.00.20	B. WIN			00/ 1 11	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
			12011 WHITTERN RD				
ADAMS H	HERITAGE			MONRO	DEVILLE, IN 46773		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	into an extension	n cord power strip in the			locked.		
	Maintenance off	ice.					
					3. What measures will be put	<u>t</u>	
	3.1-19(b)				into place or what	a da	
	3.1-17(0)				systemic changes will be ma	<u>iae</u>	
					to ensure that the		
					deficient practice does not		
					recur?		
					Refrigerator will remain unplugged until new outlet is		
					Installed.		
					installed.		
					4. How the corrective action	(s)	
					will be monitored to	107	
					ensure the deficient practice	1	
					will not recur?	_	
					Information gathered from the		
					audits will be		
					forwarded to the QA committee	26	
					for recommendations	,-	
					and review monthly for two		
					months, then quarterly		
					thereafter. QA committee will		
					recommend time		
					frame for continuing monitoring	a	
						 9∙	
					5. By what date the systemic	c	
					changes will be	_	
					completed?		
					September 26, 2014		

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